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No. 95-1729

Supreme Court, U.S.
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IN THE
# Supreme Court of the United States
OCTOBER TERM, 1995

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ROSE V. FORREST, SECRETARY,
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA. *et al.*,

*Petitioners*

v.

MYRTLE W. BLANCHARD AND PATRICE A. DUMAS,

*Respondents*

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**Petition For A Writ Of Certiorari**
**To The United States Court Of Appeals**
**For The Fifth Circuit**

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## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

The Medicaid Act at 42 U.S.C. §1396a(a)(34) provides that "A state plan for medical assistance must — provide that in the case of any individual who has been determined eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) or such assistance at the time such care and services were furnished." The questions presented with regard to this statute and the Federal Rule of Civil Procedure 56(c) & (e) are:

1. Whether the court of appeal erred in upholding the district court's order requiring the defendant to "establish a mechanism to provide for coverage of bills for medical care, supplies and services during the retroactive coverage period...where applicants have paid for such care..." when the defendant has in place a long standing procedure, approved by the federal Health Care Financing Authority, for the payment of such bills to the full extent of Medicaid coverage once the provider refunds the payment made to the patient/recipient.

2. Whether the court of appeals for the Fifth Circuit erred in affirming the district court's erroneous grant of a I motion for partial summary judgment when genuine issues of material fact remained.

## PARTIES TO THE PROCEEDINGS

The petitioner is Rose v. Forrest, in her official capacity as Secretary of the Department of Health and Hospitals, State of Louisiana. Rose V. Forrest was succeeded as Secretary of the Department by Bobby P. Jindal on January 8, 1996.

The respondents are Myrtle W. Blanchard and Patrice A. Dumas, in their capacity as named representatives of a class of plaintiffs defined by the district court.

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IN THE

# Supreme Court of the United States

October Term, 1995

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No.

ROSE V. FORREST, as Secretary of the
DEPARTMENT OF HEALTH AND HOSPITALS,
STATE OF LOUISIANA, PETITIONERS

V.

MYRTLE W. BLANCHARD AND
PATRICE A. DUMAS, RESPONDENTS

---

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

---

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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Petitioners Rose V. Forrest and the Louisiana Department of Health and Hospitals, petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a) is reported at 71 F.3d 1163. The opinion of the district court (App. B, *infra*, 16a) is not reported.

## JURISDICTION

The judgment of the court of appeals was entered on January 8, 1996. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. 1254(1) (1988).

## STATUTES AND REGULATIONS INVOLVED

Relevant provisions of 42 U.S.C. 1396a(a)(34), and 42 C.F.R. 431.54 are reprinted at App. C, *infra*, 20a.

## STATEMENT

1. The Medicaid Program

Medicaid is a joint federal-state program that subsidizes medical services to persons who are poor, blind, disabled, and aged and their children. *See* Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.* (1988). This program was established by Congress "for the purpose of providing federal financial assistance for States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297,301 (1980). If a state elects to participate in the program and to receive matching federal funds (referred to as federal financial participation or "FFP"), it must comply with the Medicaid statute and the regulations promulgated thereunder by the Health Care Financing Administration ("HCFA"), an agency of the federal Department of Health and Human Services. *Wilder v. Virginia Hosp. Ass'n.*, 496 U.S. 498, 502 (1990).

The regulatory scheme of the Medicaid program includes the above referenced federal components and a state plan, pe-

culiar to each state, which must be approved by HCFA. HCFA periodically issues policy guidelines and directives to which all state Medicaid Programs must adhere. Additionally, HCFA maintains constant oversight of all state Medicaid programs and monitors their compliance with both federal standards and each state's individual plan.

Aside from the regulatory scheme of the Medicaid Program, an equally complicated scheme of cost sharing between the federal and state governments operates on a state-by-state basis. Costs are shared by the federal and state governments. Generally, a state commits an amount of money for a Medicaid service and the federal government then "matches" that amount based upon a certain ratio of federal to state dollars. For Louisiana, the federal-state ratio is approximately 75/25. Within a state's Medicaid program, different costs are "matched" at different rates. Administrative costs for Louisiana's Medicaid program are matched on a 50/50 basis. A few costs are paid with all federal dollars.

With Louisiana's current Medicaid budget crisis, the state is critically aware of the expenditures which occasion the greatest influx of federal dollars and those which strain the state's coffers. Louisiana's dilemma is that despite her status as a rather poor state, with respect to revenues, she has a disproportionately high demand for Medicaid services for her poor. In any given twelve-month period, almost one fourth of Louisiana's citizens are eligible for Medicaid services. Thus a driving force in the establishment of optional Medicaid programs to aid Louisiana's poor, blind, aged and disabled is the availability of federal dollars, FFP, and the level of that financial participation. Fiscally, Louisiana is not in a position to spend all state dollars on any Medicaid services.

Another aspect of the Medicaid program and the mandates of HCFA involve the ability of eligible recipients to eas-

ily access services. Federal regulations state that services must be as available to the Medicaid population as to the general population. Thus, with limited resources and a substantial Medicaid population, Louisiana strives to maintain a maximum of Medicaid services which are easily accessible to all eligible recipients, while minimizing the expenditure of state dollars. It is a difficult balance to maintain.

2. The Louisiana Medicaid Process for Retroactive Coverage of Services

All state Medicaid programs are required to extend Medicaid coverage for medical services provided to a qualified recipient to include services rendered in the three months preceding the month in which an application for assistance is made. This is generally referred to as retroactive coverage. Louisiana's Department of Health and Hospitals (hereinafter "DHH") maintains the following policy on retroactive coverage:

> When retroactive payment shall not be made:
> (1) for services received in any period prior to the third month predating that of application.
> (2) for services for which payment has already been made by a source other than the Division of Family Services (the predecessor agency in charge of the Louisiana Medicaid Program), even though the person was eligible at the time of the service, excpet when the provider refunds all payment received and accepts the division's payment as payment in full (except in long term care facilities). The refund must be clearly established on the bill the provider submits to state office (now UNISYS).

The Louisiana Department of Health and Hospitals states that this policy, included in the Louisiana State Plan, has been approved by HCFA as being in compliance with Medicaid statutes and regulations. Respondents assert that this policy

fulfills the requirements of the applicable federal statutes and regulations, thus it is a valid Medicaid procedure.

## REASONS FOR GRANTING THE PETITION

The court of appeals erroneously affirmed the district court's grant of the motion for partial summary judgment regarding the petitioners' procedure for retroactive reimbursement. The court's conclusion that the petitioners' policy was flawed and that the procedure should be altered to provide either direct payment to recipients or mandatory refund by providers with subsequent payment by Louisiana Medicaid, went far beyond the proper boundaries of judicial review.

The ruling by the court of appeals is the first appellate decision dealing with the issue of retroactive reimbursement and the procedures employed by state Medicaid agencies to implement retroactive mandates from federal statutes and regulations. This case presents an opportunity for the Court to consider the intrusive effect of this lower court ruling and to reduce federal court oversight of the daily functioning of state Medicaid programs at a time when Congress, at the behest of the states, is being urged to loosen the federal controls on these programs.

### 1. THE COURT OF APPEALS' DECISION IS CONTRARY TO THE LANGUAGE AND THE INTENT OF THE MEDICAID ACT, 42 U.S.C. 1396a(a)(34).

The plaintiffs in this matter assert that the Louisiana Medicaid program and the defendant have refused to furnish assistance for services for which recipients have paid in the six months prior to application. The process involves the refund, by the provider, of the monies advanced by the recipient and then a claim by the provider to Louisiana Medicaid for reimbursement.

Medicaid is a program in which providers enroll voluntar-

ily to provide services to the poor, aged, blind and disabled and their children. When a provider agrees to furnish medical services to Medicaid recipients, the provider does not agree to treat all Medicaid patients who present themselves for treatment. All providers retain the right to limit the Medicaid patients treated. It is a matter of individual freedom.

Plaintiffs now suggest that the right to determine which patients a health care provider will treat is to be denied to Louisiana Medicaid providers by edict of the district court with the approval of the court of appeals. Plaintiffs would have Louisiana Medicaid demand that as many as six months after treatment and payment by the patient, the provider would be required to refund the fees collected, in order to bill Medicaid for the services instead. If the person had walked in with a Medicaid card at the time the services were requested, the provider would have had the freedom to refuse to accept that patient as a Medicaid patient.

An implementation of one aspect of the district court's judgment would require that the provider now treat that patient as a Medicaid patient and bill Louisiana Medicaid for all services provided, not only for the future, but or all covered services provided in the previous time period, up to as many as 180 days by the time the determination of eligibility is made.

Neither the plaintiffs nor either court ruling on this matter, have been able to point to any precise language in the Medicaid Act which mandates states to require providers to release payments made by recipients for services received and paid for in the three months prior to application. Without such precise language and with no previous federal appellate court decisions requiring such release of payments, the court of appeals in this matter has greatly increased the reach of the federal Health Care Financing Authority (HCFA) at a time when all the political trends, both nationally and at the state

levels, are in the direction of reducing federal intrusion in the individual state operations of the Medicaid program. This significant alteration in how the Louisiana Medicaid program functions would be dictated by the judiciary without a trial, without testimony and witnesses and without the input of both Congress and HCFA, regarding the preferred manner in which the program is to be conducted. Presumably, if HCFA found the Louisiana Medicaid program to be operating in violation of federal statutes and regulations, HCFA would have taken action in the manner of a disallowance of funds, an action which HCFA has hardly been reluctant to initiate with reference to the Louisiana Medicaid Program.

The case primarily relied upon by the plaintiffs, *Cohen by Cohen v. Quern*, 608 F.Supp.1324 (N.D. Ill. 1 384) is a district court opinion. As such it should have very little, if any, weight when considered by either the court of appeals or this Court. However, the court of appeals based its decision on the rather shaky principles of this case. The State of Illinois continues in litigation over the matter of retroactive coverage and the procedure of requiring Medicaid providers to refund payments to patients determined to be Medicaid eligible as long as 180 days after treatment by the provider. Petitioner stressed to the court of appeals and argues strongly here that the freedom of choice of the provider must be weighed against the responsibility of the Louisiana Medicaid program to furnish coverage for medical services and care provided prior to the date of application for assistance.

The interpretation of 42 U.S.C. 1396a(a)(34) given by the court of appeals is clearly in contravention of the legislative intent in statutorily requiring state Medicaid programs to make retroactive coverage available for specific purposes. The legislative record reveals that the accessibility of this coverage was intended to protect applicants who are eligible for medical

assistance but who do not apply for the assistance until after the services are rendered. The legislative record reveals that the intention was to provide coverage for those who received care, but had not applied for assistance "either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying." 1972 U.S.C.C.A.N. 4989, 5099.

Clearly §1396a(a)(34) was intended to benefit applicants who were unaware of the availibility of medical assistance or were unable to apply for assistance because of the exigent nature of their illness and subsequent medical care. A requirement that providers, as much as 180 days after the medical treatment or service, should be compelled to reimburse patients and bill Louisiana Medicaid instead, goes far beyond the intent evidenced in the legislative history.

Neither the court of appeals nor the plaintiffs have been able to demonstrate any federal statutory mandate requiring the Louisiana Medicaid program to compel Medicaid providers to refund monies received from patients and to accept Medicaid payment in place of the private payment. The court of appeals attempts to evade this lack of federal directive with the language that the district court has not mandated a method of complying with the order. However, mere common sense interpretation would reveal that the only two procedures which would satisfy the district court's order would be to (1) pay the recipient directly or (2) to require reimbursement by the providers and to then pay the provider the Medicaid rate. The first alternative is fraught with ample opportunity for fraud and the second is a violation of the providers' freedom to determine which Medicaid patients the provider will treat. Neither alternative is acceptable.

2. THE COURT OF APPEALS'DECISION AFFIRMING THE DISTRICT COURT'S GRANT OF THE MOTION FOR

PARTIAL SUMMARY JUDGMENT IS CONTRARY TO THE PROVISIONS OF FEDERAL RULE OF CIVIL PROCEDURE 56(c) & (e).

The standard governing motions for summary judgment is well established. Federal Rule of Civil Procedure 56 states that summary judgment will be granted if the moving party can "show there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed . R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317(1986). The cases state that if the moving party satisfies this burden, the party opposing the motion "must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e) The issue raised by the petitioner here is that the mover failed to meet this initial burden at the district court and thus the inquiry should proceed no further. Issues of fact remain as to whether the Medicaid Program has a policy which satisfies the federal mandates and, at the same time, affords equal protection to the applicants for Medicaid. Petitioner here asserts that these issues, preclude, not only the granting of the summary judgment, but also the shifting of the burden to the non-mover to dispute the allegations of the mover.

It is important to note that the standard of review of a district court's grant of a summary judgment is not to be accorded deference by the reviewing court. The court of appeals in its decision in *Abbeville General Hospital v. Ramsey*, 3 F.3d 797 (5th Cir.1993), a case also involving Louisiana's Medicaid program and its reimbursement rates for inpatient, acute care hospital services, stated:

> we review a district court's grant of summary judgment *de novo*, employing the same standard as a district court would employ under Federal Rule of Civil Procedure 56(c)....All reasonable inferences are drawn in favor of the non moving party.

According to the jurisprudence cited above, the mover's

burden is to prove that no genuine issue of material facts exists and that mover is entitled to judgment as a matter of law. The court of appeals' decision in *Abbeville* emphasizes that the standard for review of a summary judgment grant is the same standard used in the district court. In *Abbeville*, at 801, the district court granted defendants' cross motion for summary judgment and dismissed the claims of the plaintiffs.

In reversing the district court's grant of the summary judgment, the court of appeals, in addition to the comments above, acknowledged that "all reasonable inferences are drawn in favor of the non moving party." No deference is accorded the district court's determination that a grant of a summary judgment is proper. The appellate court acts as a trial court on this issue. It is the contention of the petitioner that the mover in this instance failed to meet the burden of proving that no issues of material fact existed, and, thus, the burden did not shift to the petitioners.

The initial issue to be discussed is whether plaintiffs met their burden under Fed. R. Civ. P. 56(c). It is incumbent upon the party seeking a summary judgment to "show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." It is the contention of the petitioners that the trial court erred in granting plaintiffs' motion because the Department clearly demonstrated, in its memorandum and affidavit, that factual disputes remained.

Petitioners assert that, at the very least, a dispute exists as to whether the Louisiana Medicaid plan for furnishing retroactive coverage for medical services provided to Medicaid recipients is in violation of the equal protection clause of the Fourteenth Amendment to the U.S. Constitution. The question, as properly phrased, should be whether different persons are afforded disparate procedure in the handling of their retroactive

claims, not whether disparate results ensue from the implementation of a fair and uniform policy.

Louisiana has taken pains to assure that all applicants are aware that bills for medical services provided in the three months prior to the month of application, if paid, are not coverable by Medicaid, without a refund from the provider. DHH's most recent flyer to Louisiana's Medicaid applicants and recipients clearly states that "recipients who pay for medical expenses themselves cannot be reimbursed by Medicaid."

DHH also reminds applicants that medical bills paid cannot be reimbursed unless the funds paid are first refunded to the patient in the text of the "Notice of Decision" which is issued to all applicants whose application is approved. This notice reminds applicants to request that their medical service providers submit claims for services rendered in the three months preceding the month of application directly to Medicaid for payment. It also reminds recipients that "Medicaid **cannot** reimburse you for any payments you may have already made." (Emphasis in the original)

It is undisputed that Louisiana's Medicaid agency provides coverage for Medicaid-coverable bills incurred in the three months prior to application. DHH regulations provide that bills paid privately, other than by an insurer, in whole or in part, during the time an application is pending will be paid only if the medical provider, before submitting the claim to Medicaid, voluntarily refunds the money paid by the applicant. Once the refund is made and is clearly indicated on the claim submitted to Medicaid, the provider is paid the Medicaid rate for the service. This is a fair and equitable policy. All Medicaid applicants are treated equally and are entitled to payment of their medical bills on an equal basis.

Louisiana Medicaid payment rates, as mandated by HCFA, shall not exceed the usual and customary charges paid

by private pay patients for the same service. Because of this, providers of medical services may have a disincentive to refund the private pay rate and accept Medicaid payments instead. Plaintiffs argue that this is a reason to change the current DHH policy. Defendant contends that this financial disincentive cannot be eliminated by a change in DHH policy, as ordered by the district court. It is the contention of the petitioners that rather than suffer the uncertainty of knowing that a current private pay patient may become a Medicaid patient at any time, providers of medical services will refuse to take Medicaid patients at all, and thus the access to services will be greatly reduced. This result is barely addressed by either the plaintiffs or the court of appeals, despite assertions by both the Department and, in their amicus brief, the Louisiana State Medical Society.

In sum, despite the assertions by the plaintiffs that the issue of retroactive reimbursement has been settled by the courts and the failure of the court of appeals to consider the arguments made on behalf of petitioners, the issue of how state Medicaid programs should address the issue of retroactive coverage for Medicaid recipients remains in dispute. As evidenced by the decision below, the appellate court is out of step with current jurisprudence and both legislative and executive initiatives to look beyond the routine doling out of taxpayer funds and, instead, to look to the intent and the effect of welfare programs. If the courts are intent on driving providers from participation in the Medicaid program, a decision such as that handed down by the district court and summarily affirmed by the court of appeals will go a long way toward that end.

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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# APPENDIX

APPENDIX A

**United States Court of Appeals,**
**Fifth Circuit.**

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No. 95–30168.

Myrtle W. BLANCHARD and Patrice A. Dumas,
on behalf of themselves and others similarly situated,
Plaintiffs–Appellees,

v.

Rose FORREST, in her capacity as Secretary of the
Louisiana Department of Health and Hospitals,
Defendant–Appellant.

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Jan. 8, 1996.

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Class action on behalf of Medicaid applicants was brought to challenge retroactive coverage policy of Louisiana Department of Health and Hospitals (LDHH), which policy allegedly violated federal Medicaid statutes. The United States District Court, Eastern District of Louisiana, Okla Jones, II, J., entered partial summary judgment for plaintiffs and Secretary of LDHH appealed. The Court of Appeals held that Louisiana's additional requirements for retroactive coverage for the three months prior to filing Medicaid application violated federal Medicaid statutes requiring equal treatment among Medicaid recipients.

Affirmed.

**1. Federal Courts**

Court of Appeals reviews grant of summary judgment de novo, applying same criteria used by federal district court in the first instance:

**2. Federal Civil Procedure**

Summary judgment is proper if pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that moving party is entitled to judgment as matter of law. Fed.Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

**3. Social Security and Public Welfare**

State's participation in Medicaid program is voluntary; however, if state chooses to participate, its Medicaid plan must comply with the federal Medicaid statutes and regulations promulgated by Health Care Financing Administration, which is the federal agency responsible for overseeing state Medicaid plans. Social Security Act, §§ 1901–1930, as amended, 42 U.S.C.A. §§ 1396–1396u.

**4. Social Security and Public Welfare**

Medicaid requirement known as "retroactive coverage requirement" mandates that a state Medicaid plan must make available medical assistance for covered medical services furnished to Medicaid recipient within three months prior to month in which recipient applied for Medicaid. Social Security Act, § 1902(a)(34), as amended, 42 U.S.C.A. § 1396a(a)(34).

See publication Words and Phrases for other judicial constructions and definitions.

**5. Social Security and Public Welfare**

Under federal statute and regulations, Medicaid recipient must meet three requirements to obtain retroactive medical assistance: (1) medical services or supplies covered under Medicaid plan must have been furnished; (2) during the three months prior to month in which recipient filed his Medicaid application; and (3) recipient must have been eligible for Medicaid at time the services or supplies were furnished. Social Security Act, § 1902(a)(34), as amended, 42 U.S.C.A. § 1396a(a)(34); 42 C.F.R. § 435.914(a).

**6. Social Security and Public Welfare**

Louisiana's retroactive coverage policy for Medicaid recipients, which requires, in addition to federal requirements, that medical provider first voluntarily refund payments made by Medicaid applicant and then submit claim to Louisiana Department of Health and Hospitals (LDHH) for repayment at lower Medicaid rate, violates federal Medicaid requirements that state Medicaid plan's medical assistance to any individual must not be less in amount, duration, or scope than medical assistance made available to any other individual. Social Security Act, § 1902(a)(10)(B), (a)(34), as amended, 42 U.S.C.A. § 1396(a)(10)(B), (a)(34); 42 C.F.R. § 435.914(a).

**7. Social Security and Public Welfare**

State's Medicaid plan need not only be fair and equitable, it must also comply with federal statutes and regulations. Social Security Act, §§ 1901-1930, as amended, 42 U.S.C.A. §§ 1396-1396u.

**8. Federal Courts**

Court of Appeals will not consider on appeal matters not presented to federal district court.

**9. Federal Courts**

Court of Appeals will not consider issues or arguments not raised in appellant's brief.

Appeal from the United States District Court for the Eastern District of Louisiana.

Before REYNALDO G. GARZA, KING and HIGGINBOTHAM, Circuit Judges.

PER CURIAM:

Rose Forrest, as Secretary of the Louisiana Department of Health and Hospitals, appeals from the district court's partial summary judgment for the plaintiffs. Finding no error, we affirm.

## I. BACKGROUND

Myrtle W. Blanchard ("Blanchard") and Patrice A. Dumas ("Dumas") brought this class action on behalf of Louisiana Medicaid applicants to challenge certain policies of the Louisiana Department of Health and Hospitals ("LDHH")—the state agency that administers Louisiana's Medicaid plan. Specifically, the plaintiffs argued that LDHH's retroactive coverage policy violates the federal Medicaid statute. That statute requires that Medicaid assistance be made available to an eligible Medicaid applicant for covered medical services furnished

to the applicant during the three months preceding the month in which he or she applied for Medicaid, if the applicant had been eligible for Medicaid when the services were furnished. 42 U.S.C. § 1396(a)(34). LDHH's retroactive coverage policy limits Medicaid coverage for medical expenses incurred during the retroactive coverage period, and initially paid out-of-pocket by the applicant, to instances where the medical provider voluntarily refunds the Medicaid applicant's payment, and then submits a claim evidencing the refund to LDHH.

The experiences of the named plaintiffs exemplify the dilemma created by Louisiana's retroactive coverage policy. Blanchard is a 65-year-old insulin-dependent diabetic who has a fixed income of $477 per month in Social Security benefits. In February 1994, she was found eligible for retroactive Medicaid coverage for the period from February 20, 1993 to Aplil 1993. Thereafter, Blanchard requested that the pharmacy from which she had purchased medication refund her payments totaling $197.28 and submit a claim to Medicaid. The pharmacy refused to do so. Similarly, in July 1994, Dumas's minor son was found eligible for Medicaid effective February 1, 1992. Dumas then sought refunds from pharmacies from which she had purchased $40 worth of medications for her son during the retroactive coverage period. The pharmacies denied her requests, and explained to her that such a denial was their standard policy when Medicaid clients had paid for supplies before the clients were found eligible for Medicaid.

On May 8, 1995, the district court granted the plaintiffs' motion for partial summary judgment[1], concluding that

1. The remainder of the plaintiffs' claims, involving delays in LDHH's processing of medicaid applications and appeals in violation of the federal Medicaid statute, have been resolved by the parties' agreement to a Consent Judgment, which is currently awaiting approval by the district court, and which is not made part of this appeal.

LDHH's retroactive coverage policy violates 42 U.S.C. §§ 1396a(a)(10)(B) and (34).[2] The district court ordered LDHH to "establish a mechanism to provide coverage for bills for medical care, supplies and services during the retroactive coverage period established by 42 U.S.C. § 1396a(a)(34) where applicants have paid for such care, supplies or services in whole or in part." In its Order and Reasons, the district court noted that LDHH may remedy its violation either by requiring "providers to refund payments received from services provided during the retroactive eligibility period and to then submit their claims to Medicaid, or [by] reimburs[ing] recipients directly for these expenses." Forrest appeals the grant of summary judgment, arguing, along with amicus, the Louisiana State Medical Society, that genuine issues of material fact exist, and that the district court's proposed "required refund and submit" remedy infringes the providers' right, required by federal regulations, to willingly choose Medicaid patients, and violates the Contracts Clauses of the United States and Louisiana Constitutions.

## II. STANDARD OF REVIEW

[1, 2] We review a grant of summary judgment de novo, applying the same criteria used by the district court in the first instance. *Norman v. Apache Corp.*, 19 F.3d 1017, 1021 (5th Cir.1994); *Conkling v. Turner* 18 F.3d 1285,1295 (5th Cir.1994). Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c).

2. The plaintiffs additionally argued that Louisiana's retroactive coverage policy violated due process and equal protection. However the district court did not reach these arguments in granting summary judgment, and the plaintiffs' have withdrawn their due process and equal protection arguments on appeal. Thus we shall not address these arguments.

## III. DISCUSSION

[3] Medicaid, enacted as Title XIX of the Social Security Act (codified at 42 U.S.C. §§ 1396, 1396a-u (1988)), is a joint federal-state program through which the federal government provides financial assistance to States to aid them in furnishing medical care to certain low-income or medically needy individuals. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 2513-14, 110 L.Ed.2d 455 (1990). A State's participation in the Medicaid program is voluntary; however, if a State chooses to participate, its Medicaid plan must comply with the federal Medicaid statute and regulations promulgated by the Health Care Financing Administration, the federal agency responsible for overseeing state Medicaid plans. *Id.; Abeville Gen. Hosp. v. Ramsey*, 3 F.3d 797, 800 (5th Cir.1993), *cert. denied*, —— U.S. —— 15114 S.Ct. 1542, 128 L.Ed.2d 194 (1994).

[4] Under federal Medicaid law, a state plan must provide that "the medical assistance made available to any individual ... shall not be less in amount, duration, or scope than the medical assistance made available to any other individual...." 42 U.S.C. § 1396a(a)(10)(B). "Medical assistance" is defined as "payment of part or all of the cost of the [covered] care and services (if provided in or after the third month before the month in which the recipient makes application for assistance ... ) ...." 42 U.S.C. § 1396d(a). The federal Medicaid statute also mandates that a state Medicaid plan must make available medical assistance for covered medical services furnished to the Medicaid recipient within the three months prior to the month in which the recipient applied for Medicaid ("the retroactive coverage period") if the recipient would have been eligible for Medicaid at the time the medical services were furnished. 42 U.S.C. § 1396a(a)(34).[3] This requirement is com-

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3. Section 1396a(a)(34) provides:

[I]n the case of any individual who has been determined to be eligible

monly referred to as the "retroactive coverage requirement," and the federal regulations implementing it proclaim that it mandates that all state Medicaid plans:

> make eligibility for Medicaid effective no later than the third month before the month of application if the individual—
>
> > (l) Received Medicaid services, at any time during that period, of a type covered under the plan; and
> >
> > (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

42 C.F.R. § 435.914(a).

LDHH is the state agency which administers Louisiana's state Medicaid plan. LDHH's policy on retroactive coverage, purporting to implement the requirements of 42 U.S.C. § 1396a(a)(34), provides as follows:

> When retroactive payment shall not be made
>
> > (1) for services received in any period prior to the third month preceding that of application.
> >
> > (2) for services for which payment has already been made [by] a source other than the Division of

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for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or on application would have been) eligible for such assistance at the time such care and services were furnished.

42 U.S.C. § 1396a(a)(34).

> Family Services (predecessor to the Louisiana Medicaid Program), even though the person was eligible at the time of the service, except when the provider refunds all payment received and accepts the division's payment as payment in full (except in long term care facilities). The refund must be clearly established on the bill the provider submits to state office (now UNISYS).

This policy provides coverage for Medicaid coverable bills paid privately (by the recipient, not an insurer), in whole or in part, during the retroactive coverage period, *only* if the medical provider *first* before submitting the claim to LDHH's Medicaid program, *voluntarily* refunds the money paid by the recipient, and then after making the refund, submits the bill to LDHH for payment at Medicaid rates. Because Medicaid rates are usually much lower than the rates providers charge private patients, Medicaid providers in Louisiana have a disincentive to provide voluntary refunds to patients determined to be Medicaid-eligible after the services or supplies were furnished. Even if a recipient has only partially paid the medical provider for a service rendered during the three-month retroactive coverage period, LDHH will not pay the provider the balance unless the provider first voluntarily refunds the recipient's payment. Ironically, a Medicaid applicant who fails or refuses to pay for services rendered during the three-month retroactive coverage period, will receive medical assistance from LDHH for that period, because LDHH will pay directly a provider who submits a claim for the full amount.

[5] In sum, federal law requires state Medicaid plans to make available medical assistance during the retroactive coverage period. Under the federal statute and regulations, a Medicaid recipient must meet three requirements to obtain retroactive medical assistance: (1) medical services or supplies

covered under the Medicaid plan must have been furnished; (2) during the three months prior to the month in which the recipient filed his Medicaid application; and (3) the recipient must have been eligible for Medicaid at the time the services or supplies were furnished. For Medicaid applicants who pay the provider at the time of service [4], the Louisiana policy adds a fourth requirement— that the medical provider first voluntarily refund payments made by the Medicaid applicant, and then submit a claim to LDHH for repayment at the lower Medicaid rate. Undoubtedly, few medical providers seeking to maximize their profits will volunteer such charity, as evidenced by the experiences of Blanchard and Dumas.

[6] The district court concluded that Louisiana's retroactive coverage policy violated the requirements of 42 U.S.C. §§ 1396a(a)(10)(B) and (34):

> Nothing in either provision permits a state to refuse to make assistance available for such care and services if the recipient has already paid for them. The statutory intent of these two provisions is to make Medicaid coverage during this period just as effective as it would have been if the individual had already been certified for Medicaid. The defendant's policy of leaving the availability of such coverage to the discretion of the medical provider who has interests adverse to the recipient's, clearly violates this intent.

We agree with the district court's reasoning. Under Louisiana's policy, Medicaid applicants who fail to pay their medical bills incurred during the retroactive period receive a greater amount of medical assistance than Medicaid appli-

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4. Medicaid applicants needing prescription medicines during the retroactive coverage period do not have the choice of refusing to pay, because most phamacists require direct payment when supplies are purchased.

cants who privately pay for medical supplies or services during the retroactive coverage period. This unequal treatment violates the requirement of 42 U.S.C. § 139a(a)(10) that a state plan must provide that "the medical assistance made available to any individual .... shall not be less in amount, duration, or scope than the medical assistance made available to any other individual...." *Id.* Additionally, the Louisiana policy fails to comply with 42 U.S.C. § 1396a(a)(34), by failing to make available medical assistance to all Medicaid applicants who incur covered medical expenses during the three months prior to the month of application, when the applicants were Medicaid-eligible at the time the medical services or supplies were furnished. *See Cohen by Cohen v. Quern*, 608 F.Supp. 1324, 1330-1332 (N.D.Ill.1984) (concluding that the Illinois state Medicaid plan retroactive coverage policy, identical to Louisiana's policy, falls short of the state's duty, identified in 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.914, to make medical assistance available and effective during the three months prior to the month of application).

LDHH, and amicus the Louisiana State Medical Society, argue that: (a) genuine issues of material fact exist precluding summary judgment; (b) Louisiana's current policy is fair and equitable; (c) the remedy requested by the plaintiffs and ordered by the district court—that providers be required to refund private payment and obtain substitute payment from Medicaid—violates 42 C.F.R. § 431.51(b)(1)(ii); and (d) the district court's remedy impairs the obligations of contracts in violation of the Contracts Clauses of the United States and Louisiana Constitutions. We find these arguments to lack merit.

LDHH argues that a material fact dispute exists as to "whether the Louisiana Medicaid plan for providing retroactive coverage for medical services provided to Medicaid eligi-

ble recipients is in violation of the [E]qual [P]rotection [C]lause of the Fourteenth Amendment." However, the district court's grant of summary judgment did not rest upon the Equal Protection Clause; rather, the district court concluded that Louisiana's policy conflicted with the statutory requirements of 42 U.S.C. §§ 1396a(a)(10)(B) and (34). Furthermore, the parties stipulated a long list of "Uncontested Material Facts as to Which There is No Genuine Issue to be Tried." These stipulated facts included all relevant facts describing Louisiana's retroactive coverage policy, as well as the facts regarding the particular experiences of the named plaintiffs Blanchard and Dumas. Although LDHH asserts that genuine issues of material fact exist, it fails to point out to this court a single disputed fact issue relevant to the question whether Louisiana's retroactive coverage policy complies with the requirements of the federal Medicaid statute.

[7] LDHH additionally argues that the district court erred in granting summary judgment because its current retroactive coverage policy is fair and equitable. LDHH asserts that Medicaid applicants are notified, both in a flyer given to all applicants and in the "Notice of Decision" letter sent to eligible applicants, that Medicaid cannot reimburse applicants for payments already made to a medical provider in the three months prior to the month of application, unless the provider first refunds their payment and then submits a claim. LDHH apparently misapprehends the relevant question. A State's Medicaid plan need not only be fair and equitable, it must comply with federal statutes and regulations. *See Wilder*, 496 U.S. at 502, 110 S.Ct. at 2513-14. Even if LDHH provides notice to applicants that they cannot obtain retroactive assistance unless their provider chooses to refund payment, the voluntary refund policy still fails to make available and effective medical assistance to all Medicaid applicants for supplies and services furnished during the retroactive coverage period, as required by section 1396a(a)(34).

[8,9] Additionally, LDHH, mistakenly believing that the district court ordered it to "require providers to refund payments ... and to then submit their claims to Medicaid," contends, for the first time on appeal (although this remedy was recommended by the plaintiffs in their motion for partial summary judgment), that this remedy "interfere[s] with the contract between the patient and the health care provider." Indeed, only the amicus, Louisiana State Medical Society, presented argument and authority in its appellate brief that the remedy violates the Contracts Clauses of the United States and Louisiana Constitutions. Additionally, LDHH argued at oral argument, although not in its appellate brief, that this remedy also violates 42 C.F.R. § 431.51(b)(1)(ii), which requires that a state plan must provide that a recipient may obtain Medicaid services from any provider that is "willing to furnish [the services] to that particular recipient." We will not consider on appeal matters not presented to the district court. *Quenzer v. United States (In re Quenzer)*, 19 F.3d 163, 165 (5th Cir.1993). Nor will we consider issues or arguments not raised in the appellant's brief. *Pan E. Exploration Co. v. Hufo Oils*, 855 F.2d 1106, 1124 (5th Cir.1988).

Finally, in light of LDHH's apparent misunderstanding, we wish to clarify what the district court ordered. The district court's Judgment orders that LDHH "shall establish a mechanism to provide coverage for bills for medical care, supplies and services during the retroactive coverage period established by 42 U.S.C. § 1396a(a)(34) where applicants have paid for such care, supplies or services in whole or in part." This order operates only prospectively from the date of judgment—May 8, 1995. In its Order and Reasons, the district court suggests two alternative ways in which LDHH could establish the ordered mechanism: "The defendant can remedy its violation by choosing to either require providers to refund payments received for services provided during the retroactive eligibility

period and to then submit their claims to Medicaid, or to reimburse recipients directly for these expenses."

LDHH argues at length that the first suggested remedy—requiring providers to refund private payments and submit claims to Medicaid—is unfair to medical providers because it limits their ability to choose which Medicaid patients to treat. However, it must be remembered that this suggested remedy would affect only those medical providers who have already elected to participate in the Medicaid program, as only their services would be "covered" under the Medicaid plan. *See* 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914(a). Moreover, the district court's Order and Reasons, although not entirely clear on this point, apparently does not limit LDHH to consideration of its two suggested remedies. The district court's Judgment only *orders* that LDHH "shall establish a mechanism" for providing retroactive coverage for medicaid applicants who paid their medical bills during the retroactive coverage period. The Judgment does not order LDHH to implement one of the two remedies suggested in the Order and Reasons. Rather, the broadly-phrased Judgment leaves open the possibility that LDHH may implement an entirely different remedy, so long as its approach "establishes a mechanism" to provide repayment in some form to medicaid applicants who paid their medical bills incurred during the retroactive coverage period. LDHH may thus avoid any perceived problems with one of the court's suggested alternatives by implementing the other suggested remedy, or a by developing a third, entirely different approach.

## IV. CONCLUSION

Louisiana's retroactive coverage policy, which provides medical assistance for Medicaid recipients who privately paid their Medicaid-coverable bills incurred during the retroactive coverage period only if the provider first voluntarily refunds their payment and then submits a Medicaid claim, violates the

mandates of 42 U.S.C. §§ 1396a(a)(10)(B) and (34). The district court correctly granted summary judgment for the plaintiff class of Louisiana Medicaid applicants and ordered LDHH to modify its policy to comply with federal law. For the foregoing reasons, we AFFIRM.

## APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

BLANCHARD, ET AL.

CIVIL ACTION
NO. 93-3780
SECTION S

versus

FORREST

### JUDGMENT

This matter was heard on February 15, 1995, on plaintiffs' Motion for Partial Summary Judgment. The issues having been duly heard, a decision granting the motion was rendered.

Accordingly, IT IS ORDERED that the defendant shall establish a mechanism to provide coverage for bills for medical care, supplies and services during the retroactive coverage period established by 42 U.S.C. § 1396a(a)(34) where applicants have paid for such care, supplies or services in whole or in part.

IT IS FURTHER ORDERED that the defendant shall notify all class members of the mechanism, and of the opportunity for an administrative hearing if their rights under the mechanism are violated.

New Orleans, Louisiana, this 8th day of May, 1995.

s/ Okla Jones, III

UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF LOUISIANA

BLANCHARD, et al.

versus

FORREST

CIVIL ACTION
NO. 93-3780
SECTION S

**ORDER AND REASONS**

The plaintiffs' Motion for Partial Summary Judgment was granted on February 15, 1995. Based on the uncontested facts of this matter, the Court has found "that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). Reasons in support of the issuance of the injunction are set forth below as required by Rule 65(d) of the Federal Rules of Civil Procedure.

**Background**

The plaintiffs brought this suit to address the matter of untimely rulings on Medicaid applications and appeals as well as issues of retroactive coverage. A class action was certified under Fed. R. Civ. P. 23. A partial settlement was reached on the issues of timeliness and delay. The parties settled on a program of reporting and monitoring of compliance with federally-mandated time restrictions. A hearing concerning the fairness of the class action partial settlement is required under Fed. R. Civ. P. 23(e), and is scheduled for May 15, 1995, before Magistrate Judge Ronald Fonseca.

The remaining issue concerning retroactive coverage of Medicaid was resolved as a result of the partial summary judgment granted on February 15, 1995, and is the subject of this order. Specifically, when an applicant is found eligible for Medicaid, the period of eligibility is extended retroactively, as

required by federal law. If the applicant was otherwise eligible, the retroactive coverage period generally extends back to the first day of the month of application plus three months prior. 42 U.S.C. § 1396a(a)(34); 42 C.F.R. 435.914(a).

Bills for covered medical care and services incurred during this period will be paid by Louisiana Medicaid, but only if the applicant has not made any payments on these bills. If the applicant has made such a payment, the bill will be covered only if the provider voluntarily refunds the payment and subsequently seeks reimbursement from Medicaid at its lower rate. Since refunds are generally against the providers' own self-interest, the named plaintiffs were unable to obtain refunds for bills they had paid for pharmaceuticals received during the retroactive coverage period.

**Law and Application**

The Court finds that defendant's failure to implement effective coverage for services the applicant paid for during the retroactive coverage period violates the Medicaid statute. The provisions which defendant has violated are 42 U.S.C. §§ 1396a(a)(10)(B) and (34). The former requires that "the medical assistance made available to any individual ... shall not be less in amount, duration or scope than the medical assistance made available to any other individual." The latter requires that Medicaid assistance

> be made available... for care and services included under the plan and furnished in or after the third month before the month in which he made application... for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished.

42 U.S.C. § 1396a(a)(34) (emphasis added).

Nothing in either provision permits a state to refuse to

make assistance available for such care and services if the recipient has already paid for them. The statutory intent of these two provisions is to make Medicaid coverage during this period just as effective as it would have been if the individual had already been certified for Medicaid. The defendant's policy of leaving the availability of such coverage to the discretion of the medical provider who has interests adverse to the recipient's, clearly violates this intent. *See, e.q., Cohen by Cohen v. Quern*, 608 F.Supp. 1324 (D.C.Ill. 1984); *Greenstein v. Bane*, 833 F.Supp. 1054, 1061 (S.D.N.Y 1993).

Under the defendant's policy, some Medicaid recipients receive fewer benefits than others solely because they have paid their medical bills promptly. This disparity violates the comparability requirement of 42 U.S.C. § 1396a(a)(10)(B).

The defendant can remedy its violation by choosing to either require providers to refund payments received for services provided during the retroactive eligibility period and to then submit their claims to Medicaid, or to reimburse recipients directly for these expenses.

**Conclusion**

Accordingly,

IT IS ORDERED that the defendant shall establish a mechanism to provide coverage for bills for medical care, supplies and services during the retroactive coverage period established by 42 U.S.C. § 1396a(a)(34) where applicants have paid for such care, supplies or services in whole or in part.

IT IS FURTHER ORDERED that defendant notify all class members that a mechanism has been established and that they may request an administrative hearing if they believe their rights have been violated.

New Orleans, Louisiana, this 8th day of May, 1995.

S/ Okla Jones, III

United States District Judge

# APPENDIX C

**Rule 56. Summary Judgment**

**(a) For Claimant.** A party seeking to recover upon a claim, counterclaim, or cross-claim or to obtain a declaratory judgment may, at any time after the expiration of 20 days from the commencement of the action or after service of a motion for summary judgment by the adverse party, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part thereof.

**(b) For Defending Party.** A party against whom a claim, counterclaim, or cross-claim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in the party's favor as to all or any part thereof.

**(c) Motion and Proceedings Thereon.** The motion shall be served at least 10 days before the time fixed for the hearing. The adverse party prior to the day of hearing may serve opposing affidavits. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

**(d) Case Not Fully Adjudicated on Motion.** If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a trial is necessary, the court at the hearing of the motion, by examining the pleadings and the evidence before it and by interrogating counsel, shall if practicable ascertain what material facts exist without substantial con-

troversy and what material facts are actually and in good faith controverted. It shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount of damages or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the trial of the action the facts so specified shall be deemed established, and the trial shall be conducted accordingly.

**(e) Form of Affidavits; Further Testimony; Defense Required.** Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. Sworn or certified copies of all papers or parts thereof referred to in an affidavit shall be attached thereto or served therewith. The court may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, or further affidavits. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the adverse party's pleading, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party.

**(f) When Affidavits are Unavailable.** Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present by affidavit facts essential to justify the party's opposition, the court may refuse the application for judgment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

**(g) Affidavits Made in Bad Faith.** Should it appear to the satisfaction of the court at any time that any of the affidavits presented pursuant to this rule are presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party employing them to pay to the other party the amount of the reasonable expenses which the filing of the affidavits caused the other party to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.

(As amended Dec. 27,1946, eff. Mar. 19,1948; Jan. 21,1963, eff. July 1, 1963; Mar. 2, 1987, eff. Aug. 1, 1987.)

## NOTES OF ADVISORY COMMITTEE ON RULES 1937 ADOPTION

This rule is applicable to all actions, including those against the United States or an officer or agency thereof.

Summary judgment procedure is a method for promptly disposing of actions in which there is no genuine issue as to any material fact. It has been extensively used in England for more than 50 years and has been adopted in a number of American states. New York, for example, has made great use of it. During the first nine years after its adoption there, the records of New York county alone show 5,600 applications for summary judgments. Report of the Com-plan to be in effect throughout the State, and section 1915 permits certain exceptions.

(b) *State plan requirements.* A State plan must provide that the following requirements are met:

(1) The plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State.

(2) If administered by political subdivisions of the State, the plan will be mandatory on those subdivisions.

(3) The agency will ensure that the plan is continuously in operation in all local offices or agencies through—

(i) Methods for informing staff of State policies, standards, procedures, and instructions;

(ii) Systematic planned examination and evaluation of operations in local offices by regularly assigned State staff who make regular visits; and

(iii) Reports, controls, or other methods.

(c) *Exceptions* (1) "Statewide operation" does not mean, for example, that every source of service must furnish the service State-wide. The requirement does not preclude the agency from contracting with a comprehensive health care organization (such as an HMO or a rural health clinic) that serves a specific area of the State, to furnish services to Medicaid recipients who live in that area and chose to receive services from that HMO or rural health clinic. Recipients who live in other parts of the State may receive their services from other sources.

(2) Other allowable exceptions and waivers are set forth in §§ 431.54 and 431.55.

[56 FR 8847, Mar. 1,1991; 56 FR 23022, May 20, 1991]

**§ 431.51 Free choices of providers.**

(a) *Statutory basis.* This section is based on sections 1902(a)(23) 1902(e)(2), and 1915 (a) and (b) of the Act.

(1) Section 1902(a)(23) of the Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

(2) Section 1915(a) of the Act provides that a State shall not be found out of compliance with section 1902(a)(23) solely be-

cause it imposes certain specified allowable restrictions on freedom of choice.

(3) Section 1915(b) of the Act authorizes waiver of the section 1902(a)(23) freedom of choice of providers requirement in certain specified circumstances, but not with respect to providers of family planning services.

(4) Section 1902(a)(23), as amended by section 4113(c) of OBRA '87, provides that, for services furnished after June 1988, a recipient enrolled in a primary care case-management system, an HMO, or a similar entity, may not be denied freedom of choice of qualified providers of family planning services.

(5) Section 1902(e)(2), as amended by section 4113(c)(2) of OBRA '87 provides that HMO enrollees deemed eligible only for services furnished by the HMO (while they complete a minimum enrollment period) may, as an exception, seek family planning services from any qualified provider.

(b) *State plan requirements.* A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows:

(1) Except as provided under paragraph (c) of this section, a recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is—

(i) Qualified to furnish the services; and

(ii) Willing to furnish them to that particular recipient.

This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis.

(2) A recipient enrolled in a primary care case-management system, an HMO, or other similar entity will not be restricted in freedom of choice of providers of family planning services.

(c) *Exceptions.* Paragraph (b) of this section does not prohibit the agency from—

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers: or

(3) Subject to paragraph (b)(2) of this section, restricting recipients' free choice of providers in accordance with one or more of the exceptions set forth in § 431.54, or under a waiver as provided in § 431.55.

(d) *Certification requirement.* (1) *Content of certification.* If a State implements a project under one of the exceptions allowed under § 431.54 (d), (e) or (f), it must certify to HCFA that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met.

(2) *Timing of certification.* (i) For an exception under § 431.54(d), the State may not institute the project until after it has submitted the certification and HCFA has made the findings required under the Act, and so notified the State.

(ii) For exceptions under § 431.54 (e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

**§ 431.52 Payments for services furnished out of State.**

(a) *Statutory basis.* Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) *Payment for services.* A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a

resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency;

(2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

(c) *Cooperation among States.* The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

**§ 431.53 Assurance of transportation.**

A State plan must—

(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

(b) Describe the methods that the agency will use to meet this requirement.

(Sec. 1902(a)(4) of the Act)

**§431.54 Exepctions to certain State plan requirements.**

(a) *Statutory basis.* Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a) (1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(b) *Additional services under a prepayment system.* If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to recipients who live in the area served by the organization and wish to obtain services from it.

(c) [Reserved]

(d) *Special procedures for purchase of medical devices and laboratory and X-ray tests.* The Medicaid agency may establish special procedures for the purchase of medical devices or laboratory and X-ray tests (as defined in § 440.30 of this chapter) through a competitive bidding process or otherwise, if the State assures, in the certification required under § 431.51(d) and HCFA finds, as follows:

(1) Adequate services or devices are available to recipients under the special procedures.

(2) Laboratory services are furnished through laboratories that meet the following requirements:

(i) They are independent laboratories, or inpatient or outpatient hospital laboratories that provide services for individuals who are not hospital patients, or physician laboratories that process at least 100 specimens for other physicians during any calendar year.

(ii) They meet the requirements of subpart M of part 405 or part 482 of this chapter.

(iii) Laboratories that require an interstate license under 42 CFR part 74 are licensed by HCFA or receive an exemption from the licensing requirement by the College of American Pathologists. (Hospital and physician laboratories may participate in competitive bidding only with regard to services to non-hospital patients and other physicians' patients, respectively.)

(3) Any laboratory from which a State purchases services under this section has no more than 75 percent of its charges based on services to Medicare beneficiaries and Medicaid recipients.

(e) *Lock-in of recipients who over-utilize Medicaid services.* If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following are met:

( 1 ) The agency gives the recipient notice and a opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.

(2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.

(3)The restrictions do not apply to emergency services furnished to the recipient.

(f) *Lock-out of providers.* If a Medicaid agency finds that a Medicaid provider has abused the Medicaid program, the agency may restrict the provider, through suspension or otherwise, from participating in the program for a reasonable period of time.

Before imposing any restriction, the agency must meet the following conditions:

(1) Give the provider notice and opportunity for a hearing, in accordance with procedures established by the agency.

(2) Find that in a significant number or proportion of cases, the provider has:

(i) Furnished Medicaid services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the agency; or

(ii) Furnished Medicaid services of a quality that does not meet professionally recognized standards of health care.

(3) Notify HCFA and the general public of the restriction and its duration.

(4) Ensure that the restrictions do not result in denying recipients reasonable access (taking into account geographic location: and reasonable travel time) to Medicaid services of adequate quality, including emergency services.